

**FILED** APR 15 1941

Registration District No. 299 Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Trinity Lutheran Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community 19 Yrs  
years, months or days

3. (a) PRINT FULL NAME Rosa Belle Huston

3. (b) If veteran, name war No 3. (c) Social Security No. 487 12 2759

4. Sex Femal 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Morrison Paul Huston 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased May 11 1897  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>43</u>	<u>9</u>	<u>28</u>	hr. min.

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

12. Name George Hill

13. Birthplace Pa.  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret E. Cole

15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Morrison Paul Huston

(b) Address 4112 Locust

17. (a) Burial (b) Date thereof Mar. 11 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Moriah Cemetery

18. (a) Signature of funeral director Mrs C.L. Forster

(b) Address 918 Brooklyn

19. (a) Mar 11 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson **48**  
 (c) City or town Kansas City Mo. **3**  
(If outside city or town limits, write "RURAL") **8**  
 (d) Street No. 4112 Locust  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Mar day 9  
year 1941 hour 12 minute 45 P. M.

21. I hereby certify that I attended the deceased from Mar 7th  
1941 to Mar 9 1941  
that I last saw her alive on Mar 9 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage **2 day**  
**Duration**

Due to 0:30  
Due to 9:30

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy no

**PHYSICIAN**  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury D

23. Signature Chas S. Nelson (M. D. or other) M.D.  
Address 3626 Independence Date signed 3-9-41

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Robert W. Rose

Licensed Embalmer No. 2590

P. O. Address R. O. Gmo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**